

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

CONGREGATE NUTRITION

☐ State Funds

☐ Federal Title III-C-1

Title of Project: _____

Applicant Agency: _____

Telephone Number: _____ Fax Number: _____

Official(s) authorized to sign:

Name/Title _____

Address _____

Telephone Number: _____ Extension: _____

Fax Number: _____

E-Mail: _____

Project Director: _____

Address: _____

Telephone Number: _____ Extension: _____

Fax Number: _____

E-Mail: _____

Budget Period: From: _____ To: _____

Signature: _____

Chief Executive Officer [Name & Title]

Date: _____

Federal Employee Identification Number: _____ (**9 Digits**)

Is agency part of a municipality?

_____ yes

_____ no

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

CONGREGATE NUTRITION

Name of Agency: _____

B U D G E T S U M M A R Y

<u>Budget Category</u>	<u>Total</u>	<u>Credit</u>	<u>Net Expenses</u>	<u>Admin.</u>	<u>Meals</u>
1. Personnel	\$			\$	\$
2. Travel					
3. Building Space					
4. Utilities					
5. Supplies					
6. Equipment					
7. Contract Serv.					
8. Other					
9.					
Total	\$			\$	\$

11. Resources not used as match \$ _____ **Total from page 10 of 10**
12. Project Net Cost \$ _____
13. Resources used as match \$ _____ **Total from page 10 of 10**
14. Funds requested \$ _____ **Total – per DEA award letter**
- \$ _____ **State**
- \$ _____ **Federal**

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

APPLICATION FOR TITLE III-C-1 FUNDS

Name of Agency: _____

1. PERSONNEL

Position	Salaried	Hourly Rate	Hours/Per Week	% Time on Grant	Total	Admin	Meals	Support Services
a.								
b.								
c.								
d.								
e.								
f.								
g.								
h.								
i.								
j.								
Total: \$ _____								

DEA Use: _____ %

Fringe Benefits:

Includes, but is not limited to: (Check appropriate box)

	Yes	No
Health Insurance	[]	[]
Life Insurance	[]	[]
Workers' Compensation	[]	[]
RI Unemployment	[]	[]
FICA	[]	[]
Retirement	[]	[]
Other (specify)	[]	[]

Total estimated salaries/wages/fringe benefits \$ _____

Administration	Meals	Supportive Services
\$ _____	\$ _____	\$ _____

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

APPLICATION FOR TITLE III-C-1 FUNDS

2. ESTIMATED TRAVEL

A. In-State

Estimated # of miles _____
Rate/Mile x _____
Total In-State: _____

Administration	Meals	Supportive Services
\$	\$	\$

B. Out-of- State of Rhode Island

<u>Purpose (Including, but not limited to)</u>	<u>Estimated Cost</u>
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

Total Out-of State: \$ _____

Administration	Meals	Supportive Services
\$	\$	\$

Total Meals Travel..... \$ _____

Administration	Meals	Supportive Services
\$	\$	\$

State of Rhode Island & Providence Plantations

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3. BUILDING SPACE

Location: _____ Administration Meals Supportive Serv.

Annual Rate/Sq. Foot: \$ _____

Square Footage: _____

Annual Expense: _____ \$ _____ \$ _____ \$ _____

Location: _____

Annual Rate/Sq. Foot: \$ _____ \$ _____ \$ _____ \$ _____

Square Footage: _____

Annual Expense: \$ _____ \$ _____ \$ _____ \$ _____

Location: _____

Annual Rate/Sq. Foot: \$ _____ \$ _____ \$ _____ \$ _____

Square Footage: _____

Annual Expense: \$ _____

Location: _____

Annual Rate/Sq. Foot: \$ _____ \$ _____ \$ _____ \$ _____

Square Footage: _____

Annual Expense: \$ _____

Location: _____

Annual Rate/Sq. Foot: \$ _____ \$ _____ \$ _____ \$ _____

Square Footage: _____

Annual Expense: \$ _____

Location: _____

Annual Rate/Sq. Foot: \$ _____ \$ _____ \$ _____ \$ _____

Square Footage: _____

Annual Expense: \$ _____

Total Estimated \$ _____ \$ _____ \$ _____
Build Space: _____

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Department of Elderly Affairs

APPLICATION FOR TITLE III-C-1 FUNDS

Name of Agency: _____

4. UTILITIES

A. Telephone

of telephones _____
Monthly Rate \$ _____ x 12 = \$ _____

B. All Other Utilities: Includes but is not limited to (check those that apply)

Heat \$ _____
Electricity \$ _____
Gas \$ _____
Water \$ _____
Sewer \$ _____
Other (specify) \$ _____

Total Estimated Utilities: \$ _____

Administration	Meals	Supportive Services
\$ _____	\$ _____	\$ _____

5. SUPPLIES

<u>Category</u>	<u>Estimated Cost</u>
a. Office	\$ _____
b. Maintenance	\$ _____
c. Health	\$ _____
d. Other	\$ _____
Total Estimated Supplies	\$ _____

Administration	Meals	Supportive Services
\$ _____	\$ _____	\$ _____

SUPPLIES” – All tangible personal property other than “equipment” as defined in Section 6.

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APPLICATION FOR TITLE 111-C-1 FUNDS

6. E Q U I P M E N T

<u>Item</u>	<u>Quantity</u>	<u>Cost Per Unit</u>	<u>Estimated Total Cost</u>
-------------	-----------------	----------------------	-----------------------------

Total Estimated Equipment \$_____

Administration	Meals	Supportive Services
\$	\$	\$

**“EQUIPMENT” – tangible, nonexpendable, personal property
having a useful life of more than one year and
acquisition cost of \$5000 or more per unit.**

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APPLICATION FOR TITLE III-C-1 FUNDS

Name of Agency: _____

7. CONTRACT SERVICES

<u>Services</u>	<u>Estimated Rate</u>	<u>Units of Service</u>	<u>Estimated Total Cost</u>
	\$		\$

Total Estimated Contract Service _____ **\$** _____

Administration	Meals	Supportive Services
\$	\$	\$

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APPLICATION FOR TITLE III-C-1 FUNDS

Name of Agency: _____

8. O T H E R

<u>Item Service</u>	<u>Estimated Rate</u>	<u>Units of Services</u>	<u>Estimated Total Cost</u>
---------------------	-----------------------	--------------------------	-----------------------------

\$

\$

Total Estimated Other _____ **\$** _____

Administration	Meals	Supportive Services
\$	\$	\$

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APPLICATION FOR TITLE III-C-1 FUNDS

Name of Agency: _____

9.

Administration	Meals	Supportive Services
\$	\$	\$

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Department of Elderly Affairs

APPLICATION FOR TITLE III-C-1 FUNDS

Name of Agency: _____

10. OTHER RESOURCES

Used as Match

1. Cash
Program Income

_____c/Meal x
of Meals: _____ \$ _____

Subtotal: _____

2. In-Kind

Subtotal: _____

Not Used as Match

1. Cash
USDSA Cash _____

Subtotal: _____

2. In-Kind
USDA Commodities _____

Subtotal: _____

Total Used as Match: _____

Total Not Used as Match: _____

**PLEASE REMEMBER TO INCLUDE THESE TOTALS ON YOUR BUDGET
SUMMARY TOTAL PAGE.**

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

Section I – Applicant Agency

A. Characteristics of Applicant Agency:

- 1) Briefly describe the history of the agency and its demonstrated capability to implement the proposed project. (Indicate the date of incorporation).

- 2) Is the applicant agency a minority agency?

YES [] NO []

- 3) Does the project have a Board of Directors? Describe its composition and responsibilities.

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Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

B. Project Administration

- 1) List each staff position, paid or volunteer:

Title _____

Duties _____

Title _____

Duties _____

Title _____

Duties _____

Title _____

Title _____

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Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

2. How many employees, at present, are 60+ _____
3. Describe the role that will be played by volunteers in the project:
4. Estimated annual number of volunteer hours.

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Name of Agency: _____

GRANT APPLICATION NARRATIVE

C. Project Facility

Location:

Date of last Fire Inspection:

Date of last Health:
Department Inspection:

Is the facility covered by
Applicant's Insurance for
Fire / Theft / Liability?

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Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

D. Relationship to other projects:

1. Describe plans for coordinating with other agencies / organizations.

2. List all agencies with whom the applicant has a current, written, cooperative agreement:

Agency

Purpose

Date Signed

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Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

E. Service Area / Population

Persons

Over Poverty Level

Below Poverty Level

2 Describe the major characteristics of this area.

3. Describe the composition of the elderly population in the area.

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Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

4. Describe other services available to the older population in this area.
5. Describe how the project will target economically and socially disadvantaged older persons.

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Name of Agency: _____

GRANT APPLICATION NARRATIVE

F. Other

1. Insurance: List insurance coverage maintained by the project:

Section I – Attachments enclosed:

Yes No

<input type="checkbox"/>	<input type="checkbox"/>	List of members of the board of directors.
<input type="checkbox"/>	<input type="checkbox"/>	By-laws of the board of directors.
<input type="checkbox"/>	<input type="checkbox"/>	List of members of Advisory Committee
<input type="checkbox"/>	<input type="checkbox"/>	By-laws of Advisory Committee
<input type="checkbox"/>	<input type="checkbox"/>	Current organizational chart
<input type="checkbox"/>	<input type="checkbox"/>	Copy of applicant agency incorporation papers
<input type="checkbox"/>	<input type="checkbox"/>	Current Affirmative Action Plan
<input type="checkbox"/>	<input type="checkbox"/>	Job description for each staff person
<input type="checkbox"/>	<input type="checkbox"/>	Personnel policies
<input type="checkbox"/>	<input type="checkbox"/>	Volunteer Policies
<input type="checkbox"/>	<input type="checkbox"/>	Copy of Bonding Insurance Policy
<input type="checkbox"/>	<input type="checkbox"/>	Copies of leases / deeds on facilities operated by applicant agency
<input type="checkbox"/>	<input type="checkbox"/>	Map of Service Area
<input type="checkbox"/>	<input type="checkbox"/>	HEW 641 Form
<input type="checkbox"/>	<input type="checkbox"/>	HEW 441 Form

Please provide one new set of attachments each Fiscal Year.

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Name of Agency: _____

GRANT APPLICATION NARRATIVE

Section II – Program Objectives

- a. Briefly describe the goal of this project.
- b. Describe any special conditions or arrangements necessary to accomplish the objectives listed in Section C-II.

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

A. Menus

1. Title of staff member responsible for menu preparation and certification of 1/3 the RDA:

Attach job specifications and education/experience requirements for **this position.**

2. On what basis will the project submit menus?

Monthly Menu _____

3 Month Menu _____

3. Describe the process for involving consumers in the menu planning process.

4. Describe the process for **consumer feed back** on the menus.

State of Rhode Island & Providence Plantations

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GRANT APPLICATION NARRATIVE

5. What is the project's policy describing menu posting and menu distribution?

Where are menus posted?

When are menus posted?

Are menus circulated in any other way, on a regular basis?

6. What is the title of the staff person responsible to maintain the project's official menu file (including documentation of menu changes)?

7. Will the project provide any special diets/ethnic meals? Describe.

8. Describe any special menu initiative to be undertaken this fiscal year.

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Name of Agency: _____

GRANT APPLICATION NARRATIVE

B. Food Service System

1. Meals will be (check appropriate responses):

_____ Catered # of sites _____

_____ Site Prepared # of sites _____

_____ Central Kitchen # of sites _____

_____ Home Delivered

_____ Other _____

2. Will the agency enter into any subcontracts for the operation of sites, preparation of meals, or provision of supportive services?

YES _____

NO _____

Describe

3. Will an open bidding process be utilized?

YES _____

NO _____

Describe:

4. How will meals be transported to sites – and by whom?

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

C. Project Income

1. How is the recommended donation determined?

2. The recommended donation is: \$ _____

3. What is the full cost of the meal for under 60 guests?

\$ _____

This cost includes: _____ Food/Labor/Other

_____ Administration

_____ Supportive Services

4. Employees handling funds are bonded?

YES [☐] NO [☐]

State of Rhode Island & Providence Plantations

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Name of Agency: _____

GRANT APPLICATION NARRATIVE

5. Does the project request a waiver for any portion of the DEA policy regarding collection and accounting for project income? (Explain in detail).

D. Project Council

1. Describe the composition of the Project Council and the process for election / selection.

2. Describe the composition of the site council and the process for election / selection.

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

E. U. S. D. A.

1. Describe how the project will seek to assist older persons apply for food stamps or donated foods.

2. Will USDA donated foods be used in meal preparation?

YES _____ NO _____

Bonus Commodities _____

Annual USDA Allocation Commodities _____

3. Does the agency have a signed agreement with the State Distributing Agent for USDA donated foods

YES _____ NO _____

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Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

F. Scope of Services - Meals

<u>Name & Address of Site*</u>	<u>Days of Operation</u>	<u>Daily # of Meals</u>	<u># Individuals Annually</u>
1. _____ _____ _____	_____	_____	_____
2. _____ _____ _____	_____	_____	_____
3. _____ _____ _____	_____	_____	_____
4. _____ _____ _____	_____	_____	_____
5. _____ _____ _____	_____	_____	_____
6. _____ _____ _____	_____	_____	_____
7. _____ _____ _____	_____	_____	_____
8. _____ _____ _____	_____	_____	_____

*For home delivered meals – list Routes

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Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

(Continued)

F. Scope of Services - Meals

	<u>Days of Operation</u>	<u>Daily # of Meals</u>	<u># of Individuals Annually</u>
9. _____ _____ _____	_____	_____	_____
10. _____ _____ _____	_____	_____	_____
11. _____ _____ _____	_____	_____	_____
12. _____ _____ _____	_____	_____	_____
13. _____ _____ _____	_____	_____	_____
14. _____ _____ _____	_____	_____	_____
15. _____ _____ _____	_____	_____	_____
16. _____ _____ _____	_____	_____	_____

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GRANT APPLICATION NARRATIVE

G. Scope of Services – Supportive Services

Services	Annual Service Units	Annual Unduplicated Clients
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

State of Rhode Island & Providence Plantations

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Name of Agency: _____

GRANT APPLICATION NARRATIVE

SECTION III –ATTACHEMENTS

1. Listing of Project Council Members enclosed:

YES [☐] NO [☐]

2. Copy of subcontracts enclosed:

YES [☐] NO [☐]

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Department of Elderly Affairs

Name of Agency: _____

**ANNUAL CERTIFICATION
DRUG-FREE WORKPLACE REQUIREMENTS
DEPARTMENT OF ELDERLY AFFAIRS GRANTEE AGENCIES**

This certification is required by the regulations implementing the Drug-Free Workplace Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990 Federal Register require certification by grantees, prior to award, that they will maintain a drug-free workplace. Section 76.630© of the regulations provide that a grantee that is a State may elect to make once certification in each Federal fiscal year (see Section 76.630(b) in regard to mandatory formula grants. The certification set out below is a material representation of fact upon which reliance will be placed when the agency determines to award the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government-wide supervision or debarment (see 45 C.F.R. Part 76, Sections 76.615 and 76.620).

- A. The grantee certifies that it will continue to provide a drug-free workplace by:
- (a) Publishing a statement notifying employee that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the grantee; workplace and specifying the actions that will be taken against employees for violation of such prohibition;
 - (b) Establishing an ongoing drug-free awareness program to inform about:
 - 1. the dangers of drug abuse in the workplace;
 - 2. the grantee's policy of maintaining drug-free workplace.
 - 3. Any available drug counseling, rehabilitation, and employee assistance programs; and,
 - 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.
 - (c) Making it a requirement that each employee to be engaged in the performance of the grant by giving a copy of the statement required by paragraph (a);
 - (d) Notifying the employee in the statement required by paragraph (a) that, as a conditions of employment under the grant, the employee will:
 - 1. abide by the terms of the statement; and

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ANNUAL CERTIFICATION DRUG-FREE WORKPLACE REQUIREMENTS

2. Notify the employer in writing of his/her conviction for a violation of a criminal drug statute occurring in the workplace no later than five (5) days after such conviction.
- (e) Notifying the agency, in writing, within ten (10) calendar days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction.
Employers of convicted employees must provide notice, including position title to: Division of Grants Management & Oversight Office of Management and Acquisition, U.S. Department of Health & Human Services – Room 517 D, 200 Independence Avenue, S. W. Washington, D.C. 20201. Notice shall include the identification number(s) of each affected grant.
- (f) Taking one of the following actions within thirty (30) calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted.
 1. taking appropriate action against such an employee, up to and including termination, consistent with the requirements of the *Rehabilitation Act of 1973*, as amended, or
 2. requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health law enforcement, or other appropriate agency.
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e) and (f).
- B. The grantee may insert in the space provided below the site for the performance of work done in connection with the specific grant; Place of Performance (street address, city, county, state, zip code).

Place of Performance: Name: _____

Address: _____

Name of Agency: _____

Name and Title of Authorized Representative: _____

Signature: _____

Date: _____

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

**ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE
REHABILITATION ACT OF 1973, AS AMENDED**

The undersigned (hereinafter called the "recipient") **hereby agrees that** it will comply with section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HEW regulations (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto.

Pursuant to subsection 84.5(a) of the regulations [45 C.F.R. 84.55(a)], the recipient gives this Assurance in consideration of and for the purpose of obtaining any and all federal grants, loans, contracts (except procurement contracts and contracts of insurance or guaranty), property, discounts, or other federal financial assistance extended by the Department of Health, Education & Welfare after the date of this Assurance, including payments or other assistance made after such date on applications for federal assistance that were approved before such date. The recipient recognizes and agrees that such federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States will have the right to enforce this Assurance through lawful mean. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

This Assurance obligates the recipient for the period during which federal financial assistance is extended to it by Department of Health Education and Welfare, or where the assistance is in the form of real or person property, for the period in subsection 84.5(b) of the regulations [45 C.F.R. 84.5(b)].

The recipient employs fifteen (15) or more persons, and, pursuant to section 84.7(a) or the A74 regulations [45 C.F.R. 84.7(a)], has designated the following person(s) to coordinate its efforts to comply with HEW regulations:

Chief Executive Officer

Agency Name: _____

Address: _____

FEIN: _____

Date

Signature of Chief Executive Officer

If there has been a change in name or ownership within the last year, please PRINT the former name below:

NOTE: The "A", "B", and "C" followed by numbers are for computer use: Please disregard. PLEASE RETURN ORIGINAL TO: Office of Civil Rights, Department of Health Education & Welfare, Post Office Box 8222, Washington, DC 20024.

State of Rhode Island & Providence Plantations

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TITLE VI OF THE CIVIAL RIGHTS ACT OF 1964

_____ hereby agrees that it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulations of the Department of health, Education & Welfare (45 C.F.R. Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulations, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, denied the benefits of or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and,

Hereby gives assurances that it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appears below are authorized to sign this assurance on behalf of the Applicant.

Signature: _____

Chief Executive Officer

Agency Name: _____

Address: _____

Telephone Number: _____ Extension _____

State of Rhode Island & Providence Plantations

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CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his knowledge and belief, that:

1. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.
2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influence or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit Standard Form – LLL, “*Disclosure Form to Report Lobbying*” in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including sub-contractors, sub-grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each failure.

Agency: _____

Chief Executive Officer

Agency Name: _____

Specific Agency: _____

Address: _____

Date _____